Exhibit E

DAY PITNEY LLP

BOSTON CONNECTICUT NEW JERSEY NEW YORK WASHINGTON, D.C.

GLENN E. BUTASH
Attorney at Law

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August 21, 2007

David P. Kownacki, Esq.
David P. Kownacki, P.C.
122 East 42nd Street, Suite 2112
New York, New York 10168

Re: ACS Recovery Services, Inc. v. Maria B. Figueiredo,
U.S.D.C., S.D.N.Y., Docket No. 07-CV-7359 (SCR)

Dear Mr. Kownacki:

Enclosed please find in connection with the above-referenced action:

1. Individual Rules of Judge Robinson;
2. Individual Rules of Magistrate Judge Smith;
3. 3rd Amended Instructions for Filing an Electronic Case or Appeal;
4. Procedures for Electronic Case Filing; and
5. Guidelines for Electronic Case Filing.

Very truly yours,

Glenn E. Butash

Enclosures

DAY PITNEY LLP

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Re: ACS Recovery Services, Inc. v. Maria B. Figueiredo,
U.S.D.C., S.D.N.Y., Docket No. 07-CV-7359 (SCR)

Dear Mr. Kownacki:

As you know, this firm represents ACS Recovery Services, Inc. (formerly known as Primax Recoveries Incorporated) ("ACS") in connection with the lien, in the amount of $51,415.26 plus interest, against any recovery by Maria B. Figueiredo, as administrator of the estate of Antonio Figueiredo or individually, from any third-party or -parties in connection with certain injuries suffered by Mr. Figueiredo.

Enclosed please find a copy of a Summons, Complaint, Appearance form and Rule 7.1 Statement in the action commenced by ACS against Mrs. Figueiredo in the U.S. District Court for the Southern District of New York (White Plains). In our telephone conversation on Friday, August 3, 2007, you indicated that you were authorized to accept service on behalf of Mrs. Figueiredo.

The subject lien arises as a result of the payment of medical expenses to or for the benefit of Mr. Figueiredo by The Health and Welfare Plan for Employees of Bus Associates, Inc. (the "Plan"). The Plan is an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). It is maintained by the late Mr. Figueiredo's employer, Bus Associates, Inc., and is administered for Bus Associates by Great-West HealthCare. The Plan is insured by Great-West Life Insurance Company.

The basis for ACS's lawsuit, and the relevant terms of the Plan, are described in the Complaint. The Plan's subrogation language may be found at page IV-5 to -6 (ACS0026-27) of the Plan's summary, a copy of which is enclosed.

Finally, we understand that the Supreme Court of New York, Bronx County, issued an order purporting to extinguish Great-West's lien. However, the state court lacked jurisdiction

over the issue of the enforceability of the Plan's lien. Section 502(e)(1) of ERISA (29 U.S.C. § 1132(d)(1)) provides that (except for an action brought by a plan participant or beneficiary under section 502(a)(1)(B), which is not applicable) the federal district courts "shall have *exclusive* jurisdiction of civil actions" brought under the statute. (Emphasis added.) Moreover, state laws are preempted by ERISA insofar as such laws "relate to" an ERISA plan. ERISA § 514(a), 29 U.S.C. § 1144(a).

If you have any questions, please do not hesitate to call. Otherwise, we will be expecting Mrs. Figueiredo's response to the Complaint within 20 days.

Very truly yours,

Glenn E. Butash

Enclosures

AO 440 (Rev. 8/01) Summons in a Civil Action

UNITED STATES DISTRICT COURT

Southern District of New York

ACS RECOVERY SERVICES, INC.,

V.

MARIA B. FIGUEIREDO, as Executrix of the Estate of Antonio Figueiredo, Deceased, and MARIA B. FIGUEIREDO, Individually.

SUMMONS IN A CIVIL ACTION

07 CV 7359

CASE NUMBER:

JUDGE ROBINSON

TO: (Name and address of Defendant)

Maria B. Figueiredo
46 Edgewood Avenue
Yonkers, New York 10704

YOU ARE HEREBY SUMMONED and required to serve on PLAINTIFF'S ATTORNEY (name and address)

Glenn E. Butash, Esq.
Day Pitney, LLP
7 Times Square
New York, New York 10036

an answer to the complaint which is served on you with this summons, within twenty (20) days after service of this summons on you, exclusive of the day of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the complaint. Any answer that you serve on the parties to this action must be filed with the Clerk of this Court within a reasonable period of time after service.

AUG 17 2007

J. MICHAEL McMAHON

CLERK

DATE

(By) DEPUTY CLERK

AO 440 (Rev. 8/01) Summons in a Civil Action

RETURN OF SERVICE	
Service of the Summons and complaint was made by me(1)	DATE
NAME OF SERVER *(PRINT)*	TITLE

Check one box below to indicate appropriate method of service

☐ Served personally upon the defendant. Place where served:

☐ Left copies thereof at the defendant's dwelling house or usual place of abode with a person of suitable age and discretion then residing therein.

Name of person with whom the summons and complaint were left:

☐ Returned unexecuted:

☐ Other (specify):

STATEMENT OF SERVICE FEES		
TRAVEL	SERVICES	TOTAL $0.00

DECLARATION OF SERVER

I declare under penalty of perjury under the laws of the United States of America that the foregoing information contained in the Return of Service and Statement of Service Fees is true and correct.

Executed on _____ _____
Date *Signature of Server*

_____
Address of Server

(1) As to who may serve a summons see Rule 4 of the Federal Rules of Civil Procedure.

JUDGE ROBINSON

07 CV 7359

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------X

ACS RECOVERY SERVICES, INC.,

Plaintiff,

-against-

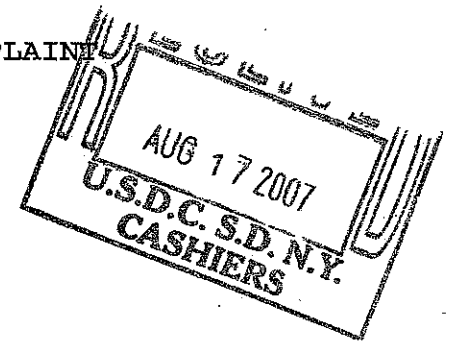
MARIA B. FIGUEIREDO, as Executrix of the Estate of Antonio Figueiredo, Deceased, and MARIA B. FIGUEIREDO, Individually,

Defendants.

----------X

Civil Action No.:

COMPLAINT



Plaintiff ACS Recovery Services, Inc. ("ACS"), by its attorneys, Day Pitney LLP, as and for its complaint against defendants Maria B. Figueiredo, as Executrix of the Estate of Antonio Figueiredo, Deceased, and Maria B. Figueiredo, individually, ("defendants"), respectfully alleges:

NATURE OF THE ACTION

1. This is an action under § 502(a)(3) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1132(a)(3), to enforce certain subrogation rights under an employee welfare benefit plan governed by ERISA. This action seeks equitable relief in accordance with the U.S. Supreme Court's decision in *Sereboff*

JUDGE ROBINSON

07 CV 7359

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------x

ACS RECOVERY SERVICES, INC.,

Plaintiff,

-against-

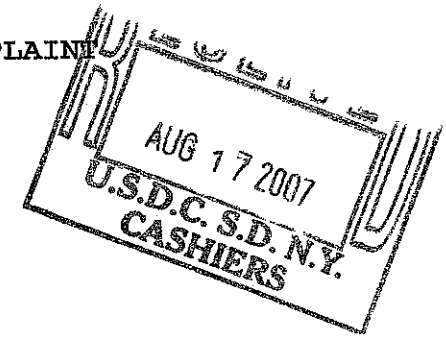
MARIA B. FIGUEIREDO, as Executrix of the Estate of Antonio Figueiredo, Deceased, and MARIA B. FIGUEIREDO, Individually,

Defendants.

----------x

Civil Action No.:

COMPLAINT



Plaintiff ACS Recovery Services, Inc. ("ACS"), by its attorneys, Day Pitney LLP, as and for its complaint against defendants Maria B. Figueiredo, as Executrix of the Estate of Antonio Figueiredo, Deceased, and Maria B. Figueiredo, individually, ("defendants"), respectfully alleges:

NATURE OF THE ACTION

1. This is an action under § 502(a)(3) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1132(a)(3), to enforce certain subrogation rights under an employee welfare benefit plan governed by ERISA. This action seeks equitable relief in accordance with the U.S. Supreme Court's decision in *Sereboff*

v. Mid Atlantic Medical Services, Inc., ___ U.S. ___, 126 S. Ct. 1869 (2006).

JURISDICTION AND VENUE

2. This Court has jurisdiction over the claims herein pursuant to ERISA § 502(e)(1), 29 U.S.C. § 1132(e)(1), and pursuant to 28 U.S.C. § 1331 (federal question).

3. Venue is proper in this District pursuant to ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2), in that the benefit plan at issue herein is administered in this District and furthermore, upon information and belief, defendants reside or may be found in this District.

PARTIES

4. ACS is, and was, at all relevant times hereinafter mentioned, a Delaware corporation maintaining its headquarters at 1301 Basswood Road, Schaumburg, Illinois. ACS formerly did business as Primax Recoveries Incorporated.

5. Upon information and belief, defendant Maria B. Figueiredo is a natural person residing at 46 Edgewood Avenue, Yonkers, New York.

6. Upon information and belief, defendant Maria B. Figueiredo is the executrix of the estate of Antonio Figueiredo, deceased.

7. Upon further information and belief, defendant Maria B. Figueiredo was the wife of Antonio Figueiredo, deceased, at the time of Mr. Figueiredo's death.

FACTS COMMON TO ALL CAUSES OF ACTION

A. ACS's Business.

8. ACS is an independent vendor of medical claims recovery and cost containment services to private healthcare payors, third-party administrators, self-funded employee benefit health plans and state and local government employee benefit health plans.

9. ACS's business is subrogation and reimbursement recovery, which involves the identification, investigation and recovery, by way of equitable enforcement of liens, of accident-related medical expenses paid or incurred by employee benefit health plans to or for the benefit of participants in such plans and their beneficiaries.

10. Pursuant to a contractual arrangement with non-party Great-West HealthCare ("Great-West"), ACS reviews and

pursues the equitable enforcement of plan liens arising as a result of the payment, by Great-West-administered plans, of medical expenses for illnesses or injuries sustained by individuals covered by such plans and for which other persons or entities have primary responsibility.

B. The ERISA Plan at Issue.

11. One such Great-West-administered plan for which ACS is subrogation recovery specialist is The Health and Welfare Plan for Employees of Bus Associates, Inc. (the "Plan"), established and maintained by non-party Bus Associates, Inc. of Yonkers, New York.

12. The Plan is an employee welfare benefit plan within the meaning of ERISA § 3(1), 29 U.S.C. § 1002(1).

13. With respect to the claims asserted herein, ACS is a "fiduciary" of the Plan within the meaning of ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A).

14. At all times relevant, Antonio Figueiredo was a participant in the Plan through his employer, Bus Associates, Inc.

C. **Mr. Figueiredo's Accident, and the Plan's Advancement of Medical Expenses on His Behalf.**

15. Upon information and belief, on or about January 22, 2003, Mr. Figueiredo sustained significant personal injuries to his head and torso as a result of an accident that occurred while performing construction work at premises known as 538 East 180th Street, Bronx, New York.

16. Upon information and belief, the circumstances surrounding the aforesaid accident and Mr. Figueiredo's injuries were such that persons other than Mr. Figueiredo were responsible, in whole or in part, for causing them.

17. As a result of the foregoing accident, the Plan incurred and paid expenses for the medical care and attention of Mr. Figueiredo in a total amount of $51,415.26.

18. Upon information and belief, on or about February 14, 2003, Mr. Figueiredo died as a result of the aforesaid injuries.

19. Upon information and belief, defendant Maria B. Figueiredo was thereafter appointed the executrix of the estate of Mr. Figueiredo.

D. The Tort Action and Mrs. Figueiredo's Negotiation of a Settlement Amount.

20. Upon information and belief, defendant Maria B. Figueiredo, in her capacity as executrix of the estate of Antonio Figueiredo and individually, commenced a civil action in the Supreme Court of the State of New York, Bronx County, against non-parties New Palace Painters Supply Co., Inc., Fran-ju, Inc., and Gerardo Marchese Inc. (collectively, the "Tort Defendants").

21. Upon information and belief, in the aforesaid action, Mrs. Figueiredo alleged that the Tort Defendants were responsible, in negligence or otherwise, for Mr. Figueiredo's injuries and death.

22. Upon further information and belief, the aforesaid action remains pending in Supreme Court, Bronx County.

23. Upon information and belief, on or about May 31, 2007, defendant Maria B. Figueiredo, in her capacity as executrix and/or individually, and the Tort Defendants (or one or more of them) agreed to resolve the aforesaid civil litigation between them for the sum if $2,800,000.00.

24. Prior to the foregoing settlement, ACS, on behalf of the Plan, notified Mrs. Figueiredo, or her counsel, of the Plan's lien and demanded that she satisfy that lien out of, and upon her receipt of, proceeds, by way of settlement or otherwise, in the aforementioned lawsuit.

25. Mrs. Figueiredo, through her counsel, refused to recognized the Plan's lien.

26. ACS, on behalf of the Plan, now brings this action in equity pursuant to ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), to enforce the Plan's lien.

AS AND FOR A FIRST CLAIM FOR RELIEF
(ERISA § 502(e)(3), 29 U.S.C. § 1132(e)(2))

27. ACS repeats and realleges each and every allegation contained in paragraphs "1" through "26" hereof as if more fully set forth herein.

28. As a result of the Plan's payment of medical expenses to or for the benefit of Antonio Figueiredo, the Plan acquired a subrogation lien--to the extent of amounts so paid --upon any recovery that his estate or Mrs. Figueiredo individually might obtain from any third-party in connection with his injuries.

29. Upon information and belief, Mrs. Figueiredo, as executrix and individually, has reached a settlement agreement with the Tort Defendants in her civil litigation commenced against them, pursuant to which Ms. Figueiredo stands to receive approximately $2,800,000.00 on account of Mr. Figueiredo's injuries and death.

30. Prior to such settlement, ACS, on behalf of the Plan, provided notice to Mrs. Figueiredo or her counsel, of the Plan's lien and further demanded that she satisfy that lien upon her receipt of, and out of, the proceeds, by way of settlement or otherwise, of the aforementioned lawsuit.

31. Mrs. Figueiredo, through her counsel, has refused to recognized the Plan's lien.

WHEREFORE, plaintiff ACS Recovery Services, Inc. respectfully demands that this Court enter judgment in its favor and against defendants Maria B. Figueiredo, as executrix of the Estate of Antonio Figueiredo, deceased, and Maria B. Figueiredo, individually:

(a) adjudging and declaring that all proceeds received by Mrs. Figueiredo, as executrix or individually, as a result of or in connection with her lawsuit against New Palace Painters Supply Co., Inc., Fran-Ju, Inc., and Gerardo

Marchese Inc. is subject to a lien in favor of ACS to the extent of (i) the lesser of such proceeds, or (ii) $51,415.26, plus interest;

(b) ordering Mrs. Figueiredo, as executrix and individually, to pay over to ACS the amounts subject to said lien in discharge of same; and

(c) granting such other and further relief as this Court deems just and appropriate.

AS AND FOR A SECOND CLAIM FOR RELIEF
(ERISA § 502(e)(3), 29 U.S.C. § 1132(e)(2))

32. ACS repeats and realleges each and every allegation contained in paragraphs "1" through "31" hereof as if more fully set forth herein.

33. As a result of the Plan's payment of medical expenses to or for the benefit of Antonio Figueiredo, the Plan acquired a subrogation lien--to the extent of amounts so paid --upon any recovery that his estate or Mrs. Figueiredo individually might obtain from any third-party in connection with his injuries.

34. Upon information and belief, Mrs. Figueiredo, as executrix and individually, has reached a settlement agreement with the Tort Defendants in her civil litigation commenced against them, pursuant to which Ms. Figueiredo

stands to receive approximately $2,800,000.00 on account of Mr. Figueiredo's injuries and death.

35. The Plan provides that, when benefits are paid in "relation to an Illness [as defined in the Plan], sickness or bodily injury,":

> [T]he Company [Great-West] may, at its option:
>
> - subrogate, that is, take over the Covered Person's right to receive payments from the Other Party. The Covered Person or his or her legal representative will transfer to the Company any rights he or she may have to take legal action arising from the Illness, sickness or bodily injury to recover any sums paid under the [Plan] on behalf of the Covered Person;
>
> - recover from the Covered Person or his or her legal representative any benefits paid under this [Plan] from any payment the [C]overed [P]erson is entitled to receive from the Other Party.
>
> The Covered Person or his or her legal representative must cooperate fully with the Company in asserting its subrogation and recovery rights. The Covered Person or his or her legal representative will, upon request from the Company, provide all information and sign and return all documents necessary to exercise the Company's rights under this provision.
>
> The Company will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration, that the Covered Person receives or is entitled to receive from any of the sources listed above. This lien will not exceed:

- the amount of benefits paid by the Company for the Illness, sickness or bodily injury . . .; or
- the amount recovered from the Other Party.

* * *

The Company's first lien rights will not be reduced due to the Covered Person's own negligence; or due to the Covered Person not being made whole; or due to attorney's fees and costs.

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the Other Party by or on behalf of:

- the Covered Person's minor covered Dependent;
- the estate of any Covered Person; or
- on behalf of any incapacitated person.

36. Pursuant to its contractual arrangement with Great-West, ACS is authorized to pursue the equitable enforcement of the aforesaid lien.

37. At all relevant times, Mr. Figueiredo was a "Covered Person" within the meaning of the Plan.

38. Upon information and belief, Mrs. Figueiredo is Mr. Figueiredo's "legal representative" within the meaning of the Plan.

39. Upon information and belief, Mrs. Figueiredo, as executrix and individually, has reached a settlement agreement with the Tort Defendants in her civil litigation commenced against them, pursuant to which Ms. Figueiredo stands to receive approximately $2,800,000.00 on account of Mr. Figueiredo's injuries and death.

40. Prior to such settlement, ACS, on behalf of the Plan, provided notice to Mrs. Figueiredo, or her counsel, of the Plan's lien and further demanded that she satisfy that lien upon her receipt of, and out of, the proceeds, by way of settlement or otherwise, of the aforementioned lawsuit.

41. Mrs. Figueiredo, through her counsel, has refused to recognized the Plan's lien.

WHEREFORE, plaintiff ACS Recovery Services, Inc. respectfully demands that this Court enter judgment in its favor and against defendants Maria B. Figueiredo, as executrix of the Estate of Antonio Figueiredo, deceased, and Maria B. Figueiredo, individually:

(a) adjudging and declaring that all proceeds received by Mrs. Figueiredo, as executrix or individually, as a result of or in connection with her lawsuit against New Palace Painters Supply Co., Inc., Fran-Ju, Inc., and Gerardo

Marchese Inc. is subject to a lien in favor of ACS to the extent of (i) the lesser of such proceeds, or (ii) $51,415.26, plus interest;

(b) ordering Mrs. Figueiredo, as executrix and individually, to pay over to ACS the amounts subject to said lien in discharge of same; and

(c) granting such other and further relief as this Court deems just and appropriate.

Date: New York, New York
August 17, 2007

DAY PITNEY LLP
Attorneys for Plaintiff,
ACS Recovery Services, Inc.

By: _____
Glenn E. Butash (GB 4695)

7 Times Square
New York, NY 10036
Telephone: (212) 297-5800
Facsimile: (212) 916-2945
Email:gbutash@daypitney.com

JUDGE ROBINSON

AO 458 (Rev. 10/95) Appearance

UNITED STATES DISTRICT COURT

Southern DISTRICT OF New York

ACS RECOVERY SERVICES, INC.,

V.

MARIA B. FIGUEIREDO, as Executrix of the Estate of Antonio Figueiredo, Deceased, and MARIA B. FIGUEIREDO, Individually.

APPEARANCE

Case Number: 07 CV 7359

To the Clerk of this court and all parties of record:

Enter my appearance as counsel in this case for

ACS Recovery Services, Inc., Plaintiff

I certify that I am admitted to practice in this court.

8/18/2007
Date

Signature

Glenn E. Butash GB4695
Print Name Bar Number

Day Pitney LLP, 7 Times Square
Address

New York, NY 10036
City State Zip Code

(212) 297-5800 (973) 966-1015
Phone Number Fax Number

JUDGE ROBINSON

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

ACS Recovery Services, Inc.,

Plaintiff

-v-

Maria B. Figueiredo,

Defendant

07 CV 7359
Case No.

Rule 7.1 Statement

Pursuant to Federal Rule of Civil Procedure 7.1 [formerly Local General Rule 1.9] and to enable District Judges and Magistrate Judges of the Court to evaluate possible disqualification or recusal, the undersigned counsel for ACS Recovery Services, Inc. (a private non-governmental party) certifies that the following are corporate parents, affiliates and/or subsidiaries of said party which are publicly held.

Affiliated Computer Services, Inc.

Date: 8/18/07

Signature of Attorney

Attorney Bar Code: GB 4695

Form Rule7_1.pdf

TABLE OF BENEFITS (HEALTH)

Plan Number: **550223**

Plan Effective Date: **JANUARY 1, 1998**

This Table of Benefits has no full meaning by itself. It must be read in conjunction with other provisions of this Booklet.

When you become covered under this Booklet, your Class will be determined according to the Class Description shown below.

TABLE OF BENEFITS (HEALTH) (Continued)

CLASS DESCRIPTION

The benefits for which you and your Dependents are covered will be those for which you are eligible for and for which you have applied.

	Active Salaried Employees, except those who have elected the HMO, and Retired Salaried Employees who were covered under the Medical Expense Reimbursement Benefit Plan prior to retirement
PLAN MAXIMUM AMOUNT	
Mental/Nervous and Substance Abuse Benefit Maximum (in-patient)	See Misc. Health Provisions
Maximum Lifetime Benefit (ALL Covered Expenses)	Unlimited

COMPREHENSIVE/MAJOR MEDICAL BENEFIT (C/MM)

Your Employer has elected a preferred provider option. Later in this Booklet you will find reference to New England PPO Hospitals and Physicians and Non-New England PPO Hospitals and Physicians. Benefits are payable for certain services of a Non-New England PPO Physician on the same basis as services of a New England PPO Physician. For details, see the COMPREHENSIVE/MAJOR MEDICAL BENEFIT (C/MM) section later in this Booklet.

Calendar Year Deductible Amount (CYD)	$250.00
Family Deductible	$500.00

	Deductible Amount	**Percentage**
Pre-admission Testing	NONE	100%
Child Birth Center	NONE	100%
Medical Management Second Opinions	NONE	100%
Home Health Care	NONE	100%
Skilled Nursing Facilities	NONE	100%

TABLE OF BENEFITS (HEALTH) (Continued)

Out-patient Surgery	NONE	100%
Preventive Care	NONE	100%
In-patient expenses or out-patient care in a New England PPO Hospital	NONE	100%
Office visits by a New England PPO Physician	NONE	100% after Co-Pay Amount of $10.00
Other doctor services by a New England PPO Physician	NONE	100%
In-patient expenses or out-patient care in a Non-New England PPO Hospital	CYD	80%
Doctor services by a Non-New England PPO Physician	CYD	80%
Spinal Adjustment and Treatment Covered Expenses	CYD	80%
Other Covered Expenses	CYD	80%
Individual Break Point		$5,000.00
Family Break Point		$10,000.00
Calendar Year Preventive Care Benefit Maximum		$300.00
Mental/Nervous and Substance Abuse Benefit Maximum (out-patient)		See Misc. Health Provisions
MEDICAL MANAGEMENT		
Medical Management Deductible Amount		
• applicable to		
- services rendered in a New England PPO Hospital if recommended by a New England PPO Physician		None
- services rendered by a New England PPO Physician		None
• applicable to other Covered Expenses		$250.00

TABLE OF BENEFITS (HEALTH) (Continued)

PRESCRIPTION DRUG EXPENSE BENEFITS

Percentage	
• If you use a network pharmacy	
- Generic Drugs	100% after $3.00 co-pay
- All Other Drugs	100% after $5.00 co-pay
• If you do not use a network pharmacy	
- Generic Drugs	50% after $3.00 co-pay
- All Other Drugs	50% after $5.00 co-pay

MAIL ORDER PRESCRIPTION DRUG EXPENSE BENEFITS

Percentage	100%
Co-Pay	$5.00

Active Salaried Employees and Retired Salaried Employees who were covered under the Medical Expense Reimbursement Benefit Plan prior to retirement

DENTALCARE BENEFIT

Calendar Year Deductible Amount applicable to:	
• Preventive Treatment	NONE
• Other Covered Dental Expenses	$100.00
Family Deductible	$200.00
Percentage applicable to:	
• Preventive Treatment	100%
• Basic Treatment	90%
• Major Treatment	60%
• Orthodontic Treatment	60%

TABLE OF BENEFITS (HEALTH) (Continued)

	Active Salaried Employees, except those who have elected the HMO, and Retired Salaried Employees who were covered under the Medical Expense Reimbursement Benefit Plan prior to retirement
Annual Maximum (for Preventive, Basic and Major Treatment)	$1,500.00
Adjusted Annual Maximum	$750.00
Orthodontic Lifetime Maximum	$1,000.00

VISIONCARE EXPENSE BENEFITS

Percentage	100%
Visual Analysis Amount	$60.00
Spectacle Lens and Frame Amount applicable to:	
• Single Vision Lenses	$120.00
• Bifocal Lenses	$138.00
• Trifocal Lenses	$150.00
• Lenticular Lenses	$192.00
Contact Lens Amount applicable to:	
• Contact Lenses for Special Conditions	$360.00
• Cosmetic Contact Lenses	$120.00

SCHEDULE OF INSURANCE (LIFE)

Group Policy No.: **450223GL**

Group Policy Effective Date: **JANUARY 1, 1998**

This Schedule of Insurance has no full meaning by itself. It must be read in conjunction with other provisions of this Booklet.

The benefits for which you are insured will be those shown below for your Insurance Class. SOI(a)

EMPLOYEE LIFE INSURANCE

Insurance Class	**Amount of Insurance**
ACTIVE SALARIED EMPLOYEES	1.5 times your Annual Earnings rounded to the next higher $1,000, up to a maximum of $262,000.00 of Basic Insurance. Excess Insurance is also available. The Total amount of insurance may not exceed $300,000.00.
Retired Salaried Employees	50% of the Employee's Life Insurance Amount that was in effect immediately prior to retirement, up to a maximum of $50,000.00

ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFIT

Insurance Class	**Amount of Insurance (Principal Sum)**
ACTIVE EMPLOYEES	An amount equal to your Life Insurance
RETIRED EMPLOYEES	Not Applicable

SCHEDULE OF INSURANCE (LIFE) (Continued)

The following overrides anything to the contrary in this Booklet. The amount of Life Insurance and Accidental Death, Dismemberment and Loss of Sight Benefit (Principal Sum) to which an active Employee is entitled under this Booklet will not be terminated due to age but will be reduced at certain ages as shown below:

Age Attained	Percentage of Benefit for which you would have been insured if you had not yet attained Age 70
70	66 2/3%
75	33 1/3%

TABLE OF INSURANCE (LTD)

Group Policy No. **450223GDH**

Group Policy Effective Date: **JANUARY 1, 1998**

This Table of Insurance has no full meaning by itself. It must be read in conjunction with other provisions of this Booklet.

The benefits for which you are insured will be those shown below for your Insurance Class:

LONG TERM DISABILITY BENEFITS

Elimination Period:	180 consecutive days
Maximum Number of Temporary Recovery Days during the Elimination Period:	10 Days

Maximum Benefit Period: The Maximum Benefit Period will be determined as shown below:

Age at Start of Total Disability	**Maximum Benefit Period**
less than 62	to age 65
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

AMOUNT OF INSURANCE: (Note: This amount will be reduced by any INCOME FROM OTHER SOURCES.)

Insurance Class	**Basic Insurance**
All Salaried Employees	An amount equal to 60% of Monthly Earnings, but in no event will the amount so determined exceed $5,000.00.
	TOI(b) Standard Plan
Minimum Monthly Benefit:	$50.00

EMPLOYEE ELIGIBILITY

You are eligible for coverage under your **Employer's** Plan if:

- you are a resident of the United States;
- you are not a temporary **Employee**;
- you are a full-time **Employee** who works at least 30.00 hours per week or you are a **Retired Employee**;
- you are classified by your **Employer** as SALARIED EMPLOYEE; and
- you are not a member of the union or covered by a collective bargaining agreement.

You must apply for coverage in writing by completing an application.

START OF YOUR COVERAGE

You are eligible on the later of the Group Policy/Plan Effective Date and the first day following the date you complete 90 days of continuous **Service**, provided that:

- you have paid the required contribution, if any; and
- you are **Actively at Work** that day. If you are not **Actively at Work**, your coverage will start on the day you return to **Work**.

If:

- you have to make a contribution towards your coverage; and
- you don't apply for coverage within 31 days of the date on which you were first eligible:

we must approve **Proof of Good Health** before coverage can begin.

DEPENDENT ELIGIBILITY

Your **Dependents** are eligible under your **Employer's Plan** if:

- they are residents of the United States or Puerto Rico; and
- you make written application to cover them under this **Plan**.

START OF DEPENDENT COVERAGE

Your **Dependents'** coverage starts when your coverage starts unless:

- a **Dependent** is **Totally Disabled.** If a **Dependent** is **Totally Disabled** when your coverage starts, his coverage will not start until he ceases to be **Totally Disabled.**

- you are required to make a contribution for your **Dependents'** coverage. In this case, you must apply for your **Dependents'** coverage within 31 days of the date you were first eligible to do so. If you make application within this 31-day period, your **Dependents'** coverage will start when your coverage starts. If you do not make application for **Dependent** coverage within this 31-day period, then you will have to submit **Proof of Good Health** for your **Dependents** to **us.** Coverage for your **Dependents** will not start until **we** approve the **Proof of Good Health** for your **Dependents.** Coverage for your **Dependents** may be denied.

If you already have **Dependent** coverage in force, then any newly acquired **Dependent** will be automatically added. If you did not elect **Dependent** coverage when you were first eligible to do so; but

- later acquire a new **Dependent;** and

- apply for coverage for the new **Dependent** within 31 days of the date you acquired the new **Dependent;**

then coverage for the new **Dependent:**

- will start on the date you acquired this **Dependent;** and

- will not be subject to **Proof of Good Health.**

We must approve **Proof of Good Health** before coverage can start for any other eligible **Dependent** whom you had previously not elected to cover.

CHANGE IN CLASS

Under this Plan, you are covered according to the Class to which you belong.

If a change occurs in your Class, you will be moved to the new Class on the date of change in status.

If the change is due to your acquiring a **Dependent** for the first time and you must make a contribution for **Dependent** coverage, then you must give notice of this change in Class to **us** within 31 days of the date on which the change occurred.

If **we** do not receive this notice, you will not be moved to the new Class until **we** approve **Proof of Good Health** for each of your **Dependents.**

CHANGES IN AMOUNTS OF COVERAGE

Changes in your amounts of coverage which result from:

- a change in the factors which determine these amounts (such as age, class or earnings); or
- an amendment which revises the amounts and/or benefits provided by the Plan;

will take place on the date of change. If you are not **Actively at Work**, the change will not take place until you return to **Work**.

Changes for **Dependents** confined in the **Hospital** on the date of the change will not take place until release from the **Hospital.**

Payment for services and supplies received before the date of a change in benefits will always be based on the Plan benefits in effect before the change.

TERMINATION OF COVERAGE

Your coverage will terminate on the earliest of these dates:

- the date on which this **Booklet** terminates. This **Booklet** will terminate automatically on the date the Group Policy/Plan sponsored by your **Employer** terminates.
- the last day of the grace period allowed for the first payment to which you or your **Employer** has failed to make a required payment. L6
- the date on which you are no longer in an eligible class. L6
- the date on which your **Service** terminates.

  For all benefits except Long Term Disability, if you are not **Actively at Work** on such date due to **Illness**, leave of absence or temporary lay-off, your coverage will be continued until the earliest of these dates: L6

  FOR EMPLOYEE HEALTH BENEFITS

  - the date on which you are employed by another employer.
  - a date determined by your **Employer**. Such date must be determined on a consistent basis for all **Employees**.
  - for leave of absence or temporary lay-off only, the date which is 31 days after the date on which your **Service** terminates.
  - for **Illness** only, the date which is 90 days after the date on which your **Service** terminates.

TERMINATION OF COVERAGE (Continued)

FOR EMPLOYEE LIFE AND AD&D BENEFITS

- the date on which you are employed by another employer;
- a date determined by your **Employer**. Such date must be determined on a consistent basis for all **Employees**;
- for leave of absence or temporary lay-off only, the date which is 6 months after the date on which your **Service** terminates;
- for sickness or injury only, subject to the DISABILITY BENEFIT, the date which is 12 months after the date on which your **Service** terminates.

FOR LONG TERM DISABILITY BENEFITS

If you are not **Actively at Work** on such date, your insurance will be continued:

- if you are receiving full salary from the **Employer**, until the date on which you are no longer receiving full salary;
- if you are in the **Elimination Period** or if you are receiving Long Term Disability Benefits, until the earlier of:
  - * the date on which you cease to be **Totally Disabled**; and
  - * the date on which your Long Term Disability Benefits cease;
- if you are on an approved leave of absence, until the earlier of:
  - * the last day of such leave of absence; and
  - * the date which is 31 days after the date on which your **Service** terminates.

Continuation of coverage is subject to the continued payment of contributions except that premiums for Long Term Disability Benefits are not required if you are receiving Long Term Disability Benefits.

L6

Your **Dependent's** coverage will terminate on the earliest of these dates:

- the date on which your coverage terminates.
- the date on which your **Dependent** is no longer eligible.
- the date on which you are no longer in a class eligible for **Dependent** coverage.
- the last day of the grace period allowed for the first payment to which you or your **Employer** has failed to make a required contribution.

Even if your **Employer** continues to make payroll deductions for your contribution after the date of termination of your coverage, your coverage will terminate on the date determined in accordance with this provision.

FAMILY AND MEDICAL CARE LEAVE

If your **Employer** approves your Family and Medical Care Leave, coverage under this **Booklet** will be continued for you and your **Dependents** during your leave, provided that any required contributions are paid by you and/or your **Employer**.

If you do not pay your contributions while you are on Family and Medical Care Leave your coverage will be discontinued. However, on the date you return to work, coverage for you and your eligible **Dependents** will be on the same basis as that provided for any other active **Employee** and his eligible **Dependents** on that date.

If you are on Family and Medical Care Leave on the effective date of this **Booklet** and were covered under the prior plan sponsored by the **Employer** on the date of its termination, then you will become covered for the benefits provided under this **Booklet** as of its effective date.

Your **Employer** may refuse to grant a Family and Medical Care Leave request under certain circumstances.

Should you have any questions about Family and Medical Care Leave, see your Plan Administrator for details.

REINSTATEMENT

For all benefits except Long Term Disability, if:

- your coverage terminates because of termination of your **Service**; and
- you return to **Work** within 2 month(s);

you will be eligible on the date you return to **Work**.

For Long Term Disability Benefits, if your insurance terminates:

- because of termination of your **Service**, then you will again become eligible on the date you return to **Work** provided that you return within 2 month(s).
- during an absence due to **Illness**, then you will again become eligible on the date you return to **Work** provided that:
  - if you **had not** qualified for benefits under this **Booklet**, you return within a period consisting of the **Elimination Period** plus 31 days; or
  - if you **had** qualified for benefits under this **Booklet**, you return within 31 days after benefits ceased to be payable.
- during a leave of absence or temporary lay-off, then you will again become eligible on the date you return to **Work** provided that you return within 2 month(s).

When you return to **Work**, your coverage will be on the same basis as that being provided on the date of your reinstatement. However, any restrictions on your coverage which were in effect before your reinstatement will continue to apply. If:

REINSTATEMENT (Continued)

- you do not return within the number of months shown above; or
- your coverage terminates because you cease to be in an eligible class and you later become a member of an eligible class;

you will be treated as a new **Employee** under the ELIGIBILITY section. L7, LTD7

If your coverage terminates because of non-payment of premiums or contributions and payments are later resumed you will be treated as a late applicant under the START OF YOUR COVERAGE section.

L7, LTD7

COBRA HEALTH CONTINUATION

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and/or your **Dependents** may qualify for continued health coverage for a specified period of time after coverage would normally terminate under this **Booklet**. Such continued benefits may last for up to 18, 29 or 36 months depending on the Qualifying Event.

The continued health coverage provided by COBRA will be the same as that provided under this **Booklet** for similarly situated individuals who have not had a Qualifying Event. The continued health coverage is subject to payment of the required COBRA premium.

Qualifying events include:

- in your case, termination of your **Service** for any reason except gross misconduct; and
- in the case of your **Dependents**:
  - your becoming entitled to **Medicare**;
  - your death;
  - divorce or legal separation;
  - your **Dependents** ceasing to qualify as **"Dependents"** under the terms of this **Booklet.**

When a Qualifying Event occurs, your **Employer** is required to provide you with the necessary COBRA election forms within the time specified by law.

You must complete and return the COBRA election form to your **Employer** within 60 days of the later of:
- the date you would lose coverage as a result of the Qualifying Event; or
- the date you receive the election form from the **Employer.**

If you or your **Dependent** receives a Social Security disability determination, you must notify the **Employer** within 60 days of the determination and before the end of the initial 18 month COBRA coverage period in order to extend COBRA coverage to 29 months.

See the CONVERSION PRIVILEGE section of this **Booklet** for information as to when you and/or your **Dependents** whose coverage is being continued under COBRA may exercise the Conversion Privilege for health coverage.

Should you have any questions about COBRA continuation, see your Plan Administrator for details.

EXTENDED BENEFITS AFTER TERMINATION

This section applies on termination of:

- this **Booklet**; or
- your coverage under this **Booklet**.

The coverage provided under this section will be subject to any maximums shown in the applicable Benefit Provision. The benefits which may be continued are described below.

FOR C/MM BENEFITS AND PRESCRIPTION DRUG BENEFITS

If:

- you are **Totally Disabled** on the date your coverage terminates; and
- expenses have been incurred for the disabling **Illness** on or before the date of termination;

then **we** will continue to pay benefits under this **Booklet**:

- for the disabling **Illness** only; and
- during the course of that **Total Disability**; and
- to the extent that benefits would have been paid if the coverage had stayed in force.

Such benefits will be continued only for those expenses that are incurred before the earliest of these dates:

- the date which is 12 months after the date your coverage terminates.
- the date on which you reach your MAXIMUM LIFETIME BENEFIT.
- the date on which your benefits have continued for the same length of time as your coverage was last in force under this **Booklet**.

FOR DENTALCARE BENEFITS

If:

- **we** have made payment of benefits for **Orthodontic Treatment**; and
- the **Covered Person's** coverage terminates;

EXTENDED BENEFITS AFTER TERMINATION (Continued)

then **we** will continue to pay benefits under this **Booklet**:

- to the extent that benefits would have been paid if the coverage had stayed in force; and
- until the end of the quarterly payment period in process on the date of termination. This quarterly payment period is outlined in the SPECIAL CONDITIONS APPLICABLE TO ORTHODONTIC BENEFITS section of the Dentalcare Benefit.

If you have incurred expenses for **Preventive, Basic** or **Major Treatment** but have not completed the treatment on the date your coverage terminates, then **we** will continue to pay benefits under this **Booklet**:

- to the extent that benefits would have been paid if the coverage had stayed in force; and
- until the date which is 30 days after the date your coverage terminates.

FOR VISIONCARE BENEFITS

No benefits will be paid for Visioncare expenses incurred after the date of termination.

FOR LONG TERM DISABILITY BENEFITS

If you are **Totally Disabled** on the date your insurance terminates, you will be entitled throughout the course of your **Total Disability** to any Long Term Disability Benefits that would have been paid if the insurance had stayed in force. LTD6

CONVERSION PRIVILEGE

FOR C/MM BENEFITS

This Conversion Privilege applies only to **Covered Persons** who are validly covered under the **C/MM** Benefit Provision of this **Booklet**.

If your coverage terminates for any reason except failure to make a required contribution, you may be able to convert your group coverage to conversion coverage. You can apply for conversion coverage only if:

- you had been covered under this **Booklet** (or any group health plan providing similar benefits which this **Booklet** replaced) for 90 days or more; and
- your **Employer's** Plan is still in force. However, you may convert your group coverage if your Employer's Plan terminates, provided it is not replaced by similar group health coverage within 30 days.

CONVERSION PRIVILEGE (Continued)

The conversion coverage will not cover:

- a person who is entitled to **Medicare** Benefits;
- a person who, on the effective date of such conversion coverage, is:
  - covered for similar benefits by any other plan or program; or
  - eligible for similar benefits under any group plan or under the requirements of any statute;

  but only if the benefits provided under such other plan and the conversion coverage would result in over-insurance.
- an **Employee** who continues to be employed by the **Employer**.

Your spouse can convert to conversion coverage if:

- you die; or
- your marriage is annulled or ends in divorce; or
- his or her coverage terminates while being continued after your death.

Your **Dependent** children can convert to conversion coverage if you die and have no surviving spouse. They can also convert if their coverage terminates because they no longer qualify as **Dependents**. This same conversion privilege applies if their coverage would otherwise terminate while being continued after your death.

The conversion coverage must be applied for within 31 days after the applicant's coverage terminates under this **Booklet**.

The conversion coverage will be effective on the day next following the date on which the applicant's coverage terminates under this **Booklet**.

No medical exam is required.

The conversion coverage does **not** provide the same benefits as this **Booklet**. If you are interested in getting conversion coverage, ask your group Plan Administrator for details regarding the benefits available and required premiums.

Exception for Persons Whose Coverage is Being Continued Under COBRA

You and/or your **Dependents** who are eligible for COBRA will only be able to exercise this Conversion Privilege at the end of the applicable 18 month or 36 month maximum period of COBRA continuation. This will be the case unless:

- your **Employer's** Plan terminates in its entirety and it isn't replaced within 30 days; or
- you or one of your eligible **Dependents** becomes ineligible for disability benefits under the Social Security Act after 18 months but before the expiration of the 29 month maximum period of COBRA continuation.

CONVERSION PRIVILEGE (Continued)

FOR EMPLOYEE LIFE INSURANCE

If all or part of your Group Term Life Insurance terminates, you may apply for an individual life insurance policy. **Proof of Good Health** will not be required if you apply within 31 days of such termination. L8

Eligible Employees

- If your insurance is not being continued under the DISABILITY BENEFIT section, you are eligible if:
  - all or part of your insurance terminates due to:
    - * termination of your **Service**;
    - * your ceasing to be in an eligible class;
    - * age or retirement reductions shown in the Schedule of Insurance; or
    - * an amendment to the Group Policy;

    but only if the Group Policy is then in force;

  or
  - all of your insurance terminates due to termination of the Group Policy.

- If your insurance is being continued under the DISABILITY BENEFIT section, you are eligible if:
  - all of your insurance terminates; or
  - part of your insurance terminates due to age or retirement reductions shown in the Schedule of Insurance. The Schedule which was in effect when you became disabled will be used.

  You may use the Conversion Privilege whether or not the Group Policy is in force. L8NY

The Individual Policy

- The policy will be one of **our** standard forms. This policy will include at your option a single premium preliminary term insurance for a period of one year. The policy will not contain any disability or accidental death benefit.

- The policy will take effect at the end of the 31 day period allowed for you to apply. During this time, the first premium must be paid to **us**. The amount of the premium will depend on your age and class of risk. L8aNY

- The amount of the policy will not exceed the amount of your current Group Term Life Insurance. L8eNY

Death Benefit

Where permitted by law, you are allowed 31 days to apply for this Conversion Privilege. If you die within this period, your beneficiary will receive a Death Benefit. The amount of such benefit will be the maximum amount of Group Term Life Insurance which you would have been eligible to convert under this section. However, if your amount of insurance had reduced during such 31-day period because of age or retirement, the Death Benefit will be the full amount of Group Term Life Insurance for which you were eligible prior to the reduction.

This Death Benefit is payable even if you had not applied for an individual policy. It is payable as a claim under the Group Policy. L8a

CONVERSION PRIVILEGE (Continued)

FOR ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT (AD&D) BENEFITS

A conversion privilege is not available for Accidental Death, Dismemberment and Loss of Sight (AD&D) Benefits.

SURVIVOR'S HEALTH BENEFIT

If your coverage under this **Booklet** terminates due to your death, any coverage for your **Dependents** will be continued without payment of contributions:

- for a period of up to 6 MONTHS after the date of your death; and
- only for those benefits for which you were covered in respect of your **Dependents** at the date of your death.

The term **"Dependent"** includes a child who:

- was conceived before but born after your death; and
- would have been covered as your **Dependent** under this **Booklet** if your coverage had stayed in force.

This continued coverage will terminate:

- for your surviving spouse, on the earliest of these dates:
  - the date of death of such spouse.
  - the date of remarriage of such spouse.
  - the date on which such spouse becomes entitled to **Medicare**.
  - the date on which such spouse becomes covered under a plan of benefits sponsored by any employer.
  - the date which is 6 MONTHS from the date of your death.
  - the date on which this **Booklet** terminates.
- for your surviving **Dependent** child, on the earliest of these dates:
  - the date of death of such child.
  - the date of remarriage of your surviving spouse.
  - the date on which such child ceases to qualify as a **Dependent** under the DEFINITIONS section.
  - the date which is 6 MONTHS from the date of your death.
  - the date on which this **Booklet** terminates.

TERMINATION OF AN EMPLOYEE'S FLEXIBLE BENEFITS ACCOUNT ELIGIBILITY

Your eligibility under this Plan will terminate on the earlier of:

- the date your employment terminates;
- the date this Plan terminates.

HOW TO FILE YOUR CLAIMS

LIFE INSURANCE

In the event of your death the Plan Administrator will contact your beneficiary to explain what is required before payment of the **Proceeds** can be made. The Plan Administrator will provide the necessary claim forms and instructions for completing them. If prompt contact is not made by the Plan Administrator, your beneficiary should take the initiative in making contact.

The **Proceeds** payable on your death will be paid to your beneficiary in a lump sum unless, by written notice to **us**, you have requested that it be payable on an installment basis as provided in this **Booklet** or be left on deposit with **us**. If you have not elected an alternative method of settlement, your beneficiary may elect one of the settlement options at your death.

AD&D INSURANCE

In the event of accidental dismemberment or loss of sight, ask your Plan Administrator for the appropriate claim forms. Ensure that these are properly completed and then return them to the Plan Administrator.

In the event of your accidental death, the Plan Administrator will contact your beneficiary to explain what is required before payment of the insurance money can be made. The Plan Administrator will provide the necessary claim forms and instructions for completing them. If prompt contact is not made by the Plan Administrator, your beneficiary should take the initiative in making contact.

LONG TERM DISABILITY INSURANCE

Ask your Plan Administrator for the proper claim forms. Complete the **Employee** portion of the claim form and send it to the Plan Administrator. Ask your **Doctor** to complete the Attending Physician's Statement and forward it to the Plan Administrator.

From time to time other forms will be sent to you for completion. Fill them in and return them promptly to your Plan Administrator. HFCLTD

HOSPITAL

Have the **Hospital** Admitting Clerk complete a **Hospital** Claim Report and attach their billing. Be sure this form includes the name of your **Employer**. The **Hospital** will forward the form directly to the Benefit Payments Office shown on the Claim Report and payment will be made directly to you or, if you so elect, to the **Hospital**.

MEDICAL

Ask your **Doctor** to complete an itemized Physician's Statement and attach his billing. Be sure the name of your **Employer** is included on this form. The **Doctor** will forward the form directly to the Benefit Payments Office shown on the Claim Report and payment will be made directly to you or, if you so elect, to the **Doctor**.

HOW TO FILE YOUR CLAIMS (Continued)

DENTALCARE

Ask your **Dentist** to complete a dental form (available from your Plan Administrator) and attach his billing. Be sure the name of your **Employer** is included on this form. The **Dentist** will forward the form directly to you or, if you so elect, to the Benefit Payments Office shown on the Claim Report and payment will be made directly to you or, if you so elect, to the **Dentist**.

VISIONCARE

Ask your **Doctor**, Ophthalmologist or Optometrist to complete a visioncare claim form (available from your Plan Administrator) and forward directly to the Benefit Payments Office shown on the Claim Report. Be sure the name of your **Employer** is included on this form. Payment will be made directly to you or, if you so elect, to your **Doctor**, Ophthalmologist or Optometrist.

PRESCRIPTION DRUGS

Your Plan Administrator will provide you with a PCS identification card when you first become covered under the group plan. Present your ID card when purchasing drugs at any of the participating pharmacies. You can obtain a list of the participating pharmacies from your Plan Administrator. Sign the pharmacy claim voucher (the pharmacy has this voucher) and pay the Pharmacist the amount, if any, shown as the "Co-Pay Amount" in your **Booklet**.

When purchasing drugs at a non-participating pharmacy, you will be required to pay the full price of the prescription. For reimbursement, ask your Plan Administrator for a PCS Prescription Drug Claim Form. Complete this claim form and mail it to the PCS address shown on the claim form. Benefit payments will be sent to you.

MAIL ORDER DRUGS

Your Mail Order Drug brochure includes an Order Form or you may obtain one from your Plan Administrator. Complete this Order Form and send it with the prescription and Co-Pay Amount shown in your **Booklet** to the Mail Order Vendor shown on the claim form. Another Order Form will be sent to you when your prescription is returned.

IF YOU INCUR EXPENSES OUTSIDE THE UNITED STATES

If you incur expenses outside the United States, you must pay the bill and file a claim to be reimbursed.

- The claim must be translated into English.
- The charges must be in U.S. currency. You are responsible for finding out the exchange rate and determining the correct amount of U.S. dollars.
- Along with the claim, you must send a receipt showing that you have paid the bill.

CO-ORDINATION OF BENEFITS (COB)

The COB provision is designed to correct overcoverage which occurs when a person has health coverage for the same expenses under two or more of the plans listed below. Should this type of duplication occur, the benefits under this Plan will be co-ordinated with those of the other plans so that the total benefits from all plans will not exceed the expenses actually incurred.

The benefits provided by the plans listed below are considered in determining duplication of coverage:

- This Plan;
- Any other group insurance or prepayment plan, including automobile "fault" or "no-fault" insurance; Health Maintenance Organizations (HMOs); Blue Cross/Blue Shield;
- Any labor-management trusteed plan, union welfare plan, employer organization plan or employee benefit organization plan;
- Any government plan or statute providing benefits for which COB is not prohibited by law;
- Any individual automobile "no-fault" insurance plan.

ORDER OF BENEFIT DETERMINATION

Certain rules are used to determine which of the plans will pay benefits first. This is done by using the **first** of the following rules which applies:

- A plan with no COB provision will determine its benefits before a plan with a COB provision.
- A plan that covers a person other than as a **Dependent** will determine its benefits before a plan that covers such person as a **Dependent**.
- When a claim is made for a **Dependent** child who is covered by more than one plan:
  - the benefits of the plan of the parent whose birthday falls earlier in a year will be determined before the benefits of the plan of the parent whose birthday falls later in that year; but
  - if both parents have the same birthday, the benefits of the plan which covered the parent longer will be determined before those of the plan which covered the other parent for a shorter period of time.

  This method of determining the order of benefits will be referred to as the "Birthday Rule". The Birthday Rule will be used to determine the order of benefits for **Dependent** children in all cases except those described below.
  - If the other plan does not have the Birthday Rule, then the plan which covers the child as a **Dependent** of the male parent will pay its benefits first.
  - If the parents are legally separated or divorced, benefits for the child will be determined in this order:
    * first, the plan of the parent with custody of the child will pay its benefits;
    * then, the plan of the spouse of the parent with custody of the child will pay its benefits; and
    * finally, the plan of the parent not having custody of the child will pay its benefits.

    However, if there is a court decree stating which parent is responsible for the health care expenses of the child, then a plan covering the child as a **Dependent** of that parent will determine its benefits before any other plan. This will be the case only if the spouse of that plan has knowledge of the court decree.

CO-ORDINATION OF BENEFITS (COB) (Continued)

- A plan that covers a person as:
  - a laid-off **Employee**; or
  - a **Retired Employee**; or
  - a **Dependent** of such **Employee**;

  will determine its benefits **after** the plan that does not cover such person as:
  - a laid-off **Employee**; or
  - a **Retired Employee**; or
  - a **Dependent** of such **Employee**.

  If one of the plans does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

- If none of the above rules establishes the order of payment, a plan under which the person has been covered for the longer time will determine its benefits before a plan covering that person for a shorter time.

  Two successive plans of the same group will be considered one plan if the person was eligible for coverage under the new plan within 24 hours after the old plan terminated. A change in the amount or scope of benefits, or a change in the carrier, or a change from one type of plan to another (e.g. single employer plan to multiple employer plan) **will not** constitute the start of a new plan.

When the COB provision reduces the benefits payable under this Plan:

- each benefit will be reduced proportionately; and
- only the reduced amount will be charged against any benefit limits under this Plan.

The COB provision is applied throughout the calendar year. If there is any reduction of the benefits provided under a specific Benefit Provision of this Plan because of duplicate coverage, similar benefits may be payable later in that year if more Allowable Expenses are incurred under the same Benefit Provision. "Allowable Expense" means any necessary, **Usual and Customary** item of expense at least part of which is covered under at least one of the plans covering the person for whom claim is made or service provided. In no event will Allowable Expense include the difference between the cost of a private hospital room and a semi-private hospital room unless the patient's stay in a private hospital room is **Medically Necessary**.

Benefits under a governmental plan will be taken into consideration without expanding the definition of "Allowable Expense" beyond the hospital, medical and surgical benefits as may be provided by such governmental plan.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

PROVISION FOR SUBROGATION AND RIGHT OF RECOVERY

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an **Illness**, a sickness, or a bodily injury incurred by you or one of your covered **Dependents** (a "**Covered Person**").

An Other Party is defined to include, but is not limited to, any of the following:

- the party or parties who caused the **Illness**, sickness or bodily injury;
- the insurer or other indemnifier of the party or parties who caused the **Illness**, sickness or bodily injury;
- a guarantor of the party or parties who caused the **Illness**, sickness or bodily injury;
- the **Covered Person**'s own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage);
- a worker's compensation insurer;
- any other person, entity, policy or plan that is liable or legally responsible in relation to the **Illness**, sickness or bodily injury.

Benefits may also be payable under this **Booklet** (herein called "the Plan") in relation to the **Illness**, sickness or bodily injury. When this happens, the Company may, at its option:

- subrogate, that is, take over the **Covered Person**'s right to receive payments from the Other Party. The **Covered Person** or his or her legal representative will transfer to the Company any rights he or she may have to take legal action arising from the **Illness**, sickness or bodily injury to recover any sums paid under the **Booklet** on behalf of the **Covered Person**;
- recover from the **Covered Person** or his or her legal representative any benefits paid under this **Booklet** from any payment the covered person is entitled to receive from the Other Party.

The **Covered Person** or his or her legal representative must cooperate fully with the Company in asserting its subrogation and recovery rights. The **Covered Person** or his or her legal representative will, upon request from the Company, provide all information and sign and return all documents necessary to exercise the Company's rights under this provision.

The Company will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration, that the **Covered Person** receives or is entitled to receive from any of the sources listed above. This lien will not exceed:

- the amount of benefits paid by the Company for the **Illness**, sickness or bodily injury plus the amount of all future benefits which may become payable under this **Booklet** which result from the **Illness**, sickness or bodily injury. The Company will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- the amount recovered from the Other Party.

If the **Covered Person** or his or her legal representative:

- makes any recovery from any of the sources described above; and

PROVISION FOR SUBROGATION AND RIGHT OF RECOVERY (Continued)

- fails to reimburse the Company for any benefits which arise from the **Illness**, sickness or bodily injury;

then:

- the **Covered Person** or his or her legal representative will be personally liable to the Company for the amount of the benefits paid under this Plan; and
- the Company may reduce future benefits payable under this Plan for any **Illness**, sickness or bodily injury by the payment that the **Covered Person** or his or her legal representative has received from the Other Party.

The Company's first lien rights will not be reduced due to the Covered Person's own negligence; or due to the Covered Person not being made whole; or due to attorney's fees and costs.

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the Other Party by or on behalf of:

- the **Covered Person**'s minor covered **Dependent**;
- the estate of any **Covered Person**; or
- on behalf of any incapacitated person.

DENIAL OF CLAIM

NOTICE OF DENIAL OF CLAIM

If any benefits are denied, either in whole or in part, notification of the specific reason or reasons for the denial will be given along with reference to the pertinent plan provisions on which the denial is based. Guidance as to the additional material or information required to perfect the claim will also be given.

Notice of any decision denying the claim must be furnished within 90 days after the claim is filed. If special circumstances require an extension of time to act on the claim, another 90 days will be allowed. If such an extension is required, notification will be given by the Plan Administrator before the end of the initial 90-day period. If the claim is not processed or a notice is not given within these time periods, the claim will be deemed to have been denied for the purpose of proceeding to the claim review procedure described below.

DENIAL OF CLAIM (Continued)

CLAIM REVIEW PROCEDURES

The process of reviewing your claim is addressed through various levels of the Benefit Payment Organization. You or your **Doctor** can direct your request for review to the Benefit Payment Office by letter or by calling the toll-free number on your ID card.

Member Services Representatives are trained to answer your questions. A Member Services Representative will respond to all inquiries within two working days. If the information does not satisfy you or your **Doctor**, a request for a claims review will be forwarded to the Member Services Supervisor in the local Benefit Payment Office.

Upon receiving your request for a claims review, TNE will:

- Let you or your **Doctor** know who may be contacted in respect to the claims review within 20 days;
- Notify you or your **Doctor** of the final disposition of the claims review within 30 days.

If your claims review is not resolved within one week it will be forwarded to the Regional Benefit Payment Manager for review and resolution.

If your claims review is not resolved by the Benefit Payment Manager, it will be forwarded to the Benefit Payment Review Department located at the TNE's Administrative Services Office in Englewood, Colorado.

The Benefit Payment Review staff may consult with TNE's:

- Medical Director (Dental Consultant if the claims review is of dental origin);
- Law Department;

to assist them in the claims review process.

You or your **Doctor** will be notified of the result of the claims review within 30 days of filing of the request for review.

FINAL APPEALS PROCESS

The final decision on appealed claims is made by either the Plan Administrator or TNE, depending upon the type of claim being appealed.

For self-funded benefits, your Plan Administrator has the exclusive and full discretion and authority to determine the benefits and amounts payable and to construe and interpret all terms and provisions of this booklet.

For insured benefits, TNE has full discretion and authority to determine the benefits and amounts payable and to construe and interpret all terms and provisions of this booklet.

DENIAL OF CLAIM (Continued)

If you or your **Doctor** is not satisfied with the final disposition of the claims review process, you can initiate an appeal by giving written notice within 60 days after you receive the written claim denial. This appeal must be filed before you may file any litigation.

You or anyone authorized to act on your behalf may appeal the claim and ask to examine any pertinent documents. Submit in writing the reasons why you believe that the claim should not have been denied, as well as any other information, questions or appropriate comments.

Appeals must be submitted in writing:

- To TNE for insured benefits;
- To the Plan Administrator for self-funded benefits.

DECISION ON REVIEW

Notification of the final decision will be given 60 days after receipt of a request for review unless special circumstances, such as a Peer Review Board review of the claim, require an extension of time for processing, in which event a further 60 days will be allowed.

ERISA GENERAL INFORMATION

- Name of Plan:

  Health and Welfare Plan for **Employees** of BUS ASSOCIATES, INC. .

- Policyholder/**Employer**:

  BUS ASSOCIATES, INC.
  475 SAW MILL RIVER ROAD
  P.O. BOX 624
  YONKERS, NY 10703

- Employer Identification Number (EIN) assigned to the Plan Sponsor by IRS:

  13-2652498

- Plan number assigned by the Plan Sponsor/**Employer**:

  501

- Type of Plan:

  Life Insurance
  Accidental Death, Dismemberment and Loss of Sight Insurance
  Long Term Disability Income Insurance
  Hospital Benefits
  Medical Benefits
  Dentalcare Benefits
  Visioncare Benefits
  Prescription Drug Benefits
  Flexible Benefits Account

- Funding:

  The New England Mutual Life Insurance Company completely funds the following benefits:

  Life Insurance
  Accidental Death, Dismemberment and Loss of Sight Insurance
  Long Term Disability Income Insurance

ERISA GENERAL INFORMATION (Continued)

The **Employer** completely funds and is fully responsible for the "self-funded" benefits listed below.

TNE processes claims and provides other services to the **Employer** related to the self-funded benefits. TNE does not insure or guarantee the self-funded benefits.

For self-funded benefits, the Plan Administrator has complete authority to control and manage the **Employer**'s Plan and has full discretion to determine eligibility, to interpret the **Employer**'s Plan and to determine whether a claim should be paid or denied, according to the provisions of the **Employer**'s Plan as set forth in this **Booklet**.

The following benefits are self-funded:

Hospital Benefits
Medical Benefits
Dentalcare Benefits
Visioncare Benefits
Prescription Drug Benefits

- Type of Administration:

  Contract Administration

- Plan Administrator:

  DIRECTOR OF HUMAN RESOURCES
  BUS ASSOCIATES, INC.
  475 SAW MILL RIVER ROAD
  P.O. BOX 624
  YONKERS, NY 10703
  (914) 376-6411

- Agent for service of legal process:

  Plan Administrator (see above)

- The eligibility requirements, termination provisions and a description of the circumstances which may result in disqualification, ineligibility, or denial or loss of any benefits are described in this **Booklet**.

- The sources of contributions to the plan:

  Employee Coverages -
  - Life and AD&D Insurance - Employer
  - LTD Insurance - Employer
  - Health Benefits - Employee/Employer
  - Flexible Benefits Account - Employee

  Dependent Coverages - Employee/Employer

- The date of the end of the year for purposes of maintaining the plan's fiscal records:

  DECEMBER 31

ERISA GENERAL INFORMATION (Continued)

- Claims - The procedures to be followed in presenting claims for benefits under the plan and the remedies for the redress of claims which are denied in whole or in part are described in this **Booklet**.

- Statement of ERISA Rights:

  As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:
  - Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
  - Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.
  - Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

  In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the **Employee** benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your **Employer**, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g. if it finds your claim is frivolous). If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

PLAN MODIFICATION/TERMINATION

The **Employer** intends to provide benefits under the **Plan** indefinitely. However, the **Employer** may at any time:

- change the contributions you must pay for benefits; or

PLAN MODIFICATION/TERMINATION (Continued)

- amend or terminate the benefits provided to you in the **Plan**.

If your **Employer**, through its acting management, decides that the **Plan** benefits should be amended or the **Plan** terminated for any reason, a designated representative of the **Employer** will prepare a written notice approved and signed by the Plan Administrator or any other person to whom the **Employer** gives authority to amend or terminate **Plan** benefits. The notice will be given to you within the time allowed by federal law. Your Plan Administrator can tell you who is responsible for approving **Plan** amendments or a **Plan** termination and the time in which notice of amendments or termination must be provided to you.

If the **Plan** is amended or terminated it will not affect the payment of any claims for expenses incurred prior to the time the change is made.

GENERAL DEFINITIONS

In this **Booklet**:

- "**Accidental Injury**" means a sudden and unforeseen event which:
  - causes injury to the physical structure of the body; and
  - results from an external agent or trauma; and
  - is definite as to time and place; and
  - happens involuntarily or, if it is the result of a voluntary act, entails unforeseen consequences.

  It does not include harm resulting from disease.

- "**Actively at Work**" means employment on an active and full-time basis at the **Employer's** usual and customary place of business. It does not include work performed away from the **Employer's** usual and customary place of business unless it is a location to which the **Employer's** business requires you to travel.

- "**Annual Earnings**" means 12 times your monthly pay received from the **Employer** in effect on JANUARY 1. This does not include:
  - overtime or bonuses; or
  - earnings from other employers;

  but it does include commissions.

- "**Booklet**" means the **Booklet** with an effective date of JANUARY 1, 1998, as amended from time to time. This **Booklet** describes your benefits and forms part of the Group Policy/Plan.

- "**C/MM**" means the Benefit Provision entitled COMPREHENSIVE/MAJOR MEDICAL EXPENSE BENEFITS.

- "**Covered Person**" means you and those of your **Dependents** who are covered under this **Booklet**.

- "**Custodial Care**" means the kind of care which helps a person meet the activities of daily living. **Custodial Care** includes but is not limited to:
  - help in walking.
  - help in getting in and out of bed.
  - help in bathing, dressing, feeding and using the toilet.
  - preparation of special diets.
  - housekeeping.
  - supervision of medication which:
    * does not need the continuing attention of trained medical or paramedical personnel; and
    * can usually be administered by:
      - the person himself; or
      - a member of his family; or
      - any other person who has not had formal medical training.

GENERAL DEFINITIONS (Continued)

- **"Dentist"** and **"Oral Surgeon"** mean persons licensed to practice dentistry.

- **"Dependent"** means:
  - your legal spouse; and
  - any child:
    - * who has not reached age 23; and
    - * who is not married; and
    - * who is chiefly dependent upon you for support; and
    - * for whom you are entitled to an income tax exemption.

  The requirements that you be entitled to an income tax exemption for the child and that the child be chiefly dependent upon you for support will not apply if the child is eligible for coverage because of a Qualified Medical Child Support Order.

  The age limit shown above does not apply to a child who cannot support himself due to mental retardation or physical handicap. The income tax exemption requirement shown above is also waived for such a child. However, the child must have been covered under this **Booklet** on the day before the date he would otherwise lose his **Dependent** status due to age as described above. Within 6 months prior to such date, and at reasonable intervals after that, **we** may require proof of his incapacity in the form of a **Doctor's** certificate. If such proof is not provided within 60 days of the request the child's coverage under this **Booklet** will terminate.

  "Dependent" does not include:
  - any person who is covered under this **Booklet** as an **Employee**; or
  - any person who is not a resident of the United States.

  The term "child" means:
  - your children. This includes any legal step-child, adopted child or foster child.

    NOTE: In the case of an adopted child, coverage will begin during the waiting period prior to the finalization of the child's adoption. You must inform the Plan Administrator of the date on which such waiting period began.
  - any natural child of your minor **Dependent**.

- **"Doctor"** means a person licensed to practice medicine or osteopathy. **Doctor** also includes any other practitioner of the healing arts if:
  - he performs a service;
    - * within the scope of his license; and
    - * for which this **Booklet** provides coverage;

  and
  - state law requires such service to be covered.

- **"Elimination Period"** means a period of consecutive days of disability for which no benefits are payable. The **Elimination Period** is shown in the Table of Insurance (LTD).

- **"Employee"** means a person in the **Service** of the **Employer**. L3

  This includes a **Retired Employee** as defined herein. L3

  "Employee" does not include any person who is not a resident of the United States or Puerto Rico.

GENERAL DEFINITIONS (Continued)

- **"Employer"** means:
  - BUS ASSOCIATES, INC. ; and
  - any Affiliated Companies listed in the application of the **Employer**, including Liberty Lines Transit and Liberty Lines Express. The **Employer** may add an Affiliated Company after the effective date of this **Booklet**. For that company only, the effective date of the **Booklet** will be considered to be the effective date of the amendment which adds that company.

- **"Experimental or Investigational"** treatment or procedure.

  A drug, device, medical treatment or procedure which:
  - Cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) or other governmental agency and such approval has not been granted at the time of its use or proposed use; or
  - Is the subject of a current investigational new drug or new device application on file with the FDA; or
  - Is being provided pursuant to:
    * A Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial; or
    * A written protocol which describes among its objectives, determinations of safety, toxicity, effectiveness, or effectiveness in comparison to conventional alternatives;
  - Is being delivered, or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations particularly those of the FDA or the Department of Health and Human Services (HHS);
  - In the predominant opinion among experts:
    * As expressed in the published, authoritative literature, is substantially confined to use in research settings;
    * Is subject to further research in order to define safety, toxicity, effectiveness, or effectiveness compared with conventional alternatives; or
    * Is experimental, investigational, unproven or is not a generally acceptable medical practice; or
  - Is not a covered service under Medicare because it is considered investigational or experimental as determined by the Health Care Financing Administration (HCFA) of HHS;
  - Is provided concomitantly to a treatment, procedure, device or drug which is experimental, investigational, unproven Treatment; or
  - Has not been performed at least ten (10) times and reported on in United States peer review medical literature.

  TNE's Medical Director may, in his/her sole discretion, determine that a drug, device, medical treatment or procedure which is deemed experimental or investigational treatment or procedure should nonetheless not be deemed experimental or investigational treatment or procedure.

- **"Health Benefits"** means all Benefit Provisions contained in the Benefit Details tab of this **Booklet.**

- **"Hospital"** means any of the following:
  - an institution which meets all of the requirements shown below. It must:
    * be legally established as a hospital.
    * be open at all times.
    * be operated chiefly for the care of sick and injured persons as in-patients.
    * have a **Doctor** available at all times.

  * have a registered nurse on duty at all times.
  * have organized facilities for diagnosis and major surgery. For LTD benefits, for treatment of mental illness an institution that does not have surgical facilities will still qualify as a hospital if it satisfies the definition of a **"Hospital"** in all other respects. LTD3
  * not be chiefly:
    - a clinic;
    - a nursing home;
    - a rest home;
    - a convalescent home or similar place;
    - a place for rehabilitation of alcoholics or drug addicts; or
    - a place for **Custodial Care**.

- an institution which meets all of the requirements shown below. It must:
  * be legally established as a hospital.
  * be operated chiefly for the care of sick and injured persons as in-patients.
  * satisfy requirements, other than those above, specified by the law of the state where the **Covered Person** lives.
- if state law so requires, an institution which meets all of the requirements shown below. It must:
  * provide treatment for a specific condition.
  * be licensed by the state licensing body or approved by the department responsible for such facilities in the geographical area in which it is located.
  * provide recognized treatment for the condition for which it is licensed or approved to operate.
- an ambulatory surgical center which:
  * is licensed by the department responsible for the licensing of such facilities in the geographical area in which it is located; and
  * meets all of the requirements shown below. It must:
    - have an organized staff of **Doctors**.
    - have permanent facilities that are equipped and operated mainly for surgical procedures.
    - have a contract with at least one nearby hospital for immediate acceptance of patients who require hospital care after care in the center.
    - not allow patients to stay overnight.
    - provide continuous services of **Doctors** and registered nursing services whenever a patient is in the center.
- a child-birth center which:
  * is licensed by the department responsible for the licensing of such facilities in the geographical area in which it is located; and
  * has permanent facilities which are equipped and operated mainly for child-birth; and
  * provides continuous service by **Doctors**, registered nurses or mid-wife nurse practitioners when a patient is in the center.

- **"Illness"** means:
  - an **Accidental Injury**; or
  - a bodily or mental disorder; or
  - pregnancy;

  and will be determined by **us**.

  Note: Treatment of weight loss will not be considered treatment of an **Illness** unless the **Covered Person** is morbidly obese. Morbid obesity will be determined by **us**.